

## AFFIDAVIT

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C.A. NO. \_\_\_\_\_

STATE OF ALABAMA

I, Danyle Ellis, RN, hereby certify and affirm that I am a  
Registered Nurse at Staton Correctional Center; that I am one of the  
 custodians of inmate medical records at this institution; that the attached documents are true, exact, and  
 correct photocopies of certain documents maintained here in the institutional medical file of one  
John Laman, AIS NO. 234821; and that I am over the age of twenty-one  
 years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of  
 business at the Staton Correctional Center; and that said documents (and the entries  
 therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person  
 with knowledge of such act, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 12<sup>th</sup> day of September, 2005.

Danyle Ellis

SWORN TO SUBSCRIBED before me this the 12 day of September, 2005

Margaline B. Diem  
 NOTARY PUBLIC  
 SEAL

My Commission Expires 12 08 06



## ALABAMA DEPARTMENT OF CORRECTIONS

## PROBLEM LIST

INMATE NAME Inman, John AIS# 234821Medication Allergies: NKDAMedical: Chronic (Long-Term) Problems  
Roman Numerals for Medical/SurgicalMental Health Code: SMI HARM HIST NONE  
Capital Letter for Psychiatric BehaviorBipolar 0/0

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
5-27-04	PPD - <del>Om</del>			
	L1 Spinal Compression (Per MRI 3/04)			
	Hep C+			
28 AUG 04	MH Rev → SMI - intx /			
	OK / Dr. Fisher			

\*\*If Asthmatic label: Mild - Moderate - or Severe.

**PHS**PRISON  
HEALTH  
SERVICES  
INCORPORATED**YEARLY HEALTH EVALUATION****I. HISTORY – (LPN or RN)**

YES

NO

COMMENT(S)

Weight Change (greater 15 lbs.)  
(Compare Weight Below)

✓

Last weight at least 6 months ago

Persistent Cough

✓

Chest Pain

✓

Blood in Urine or Stool

✓

Difficult Urination

✓

Other Illnesses (Details)

✓

Smoke, Dip or Chew

✓

ALLERGIES

✓

Hep C / Back pain  
neckWeight 182 Temp 98.3 Pulse 80 Resp 18 Blood Pressure 144/22Eye Exam: 20 OD 20 OS 20 OU 20 If greater than > 140/90, repeat in 1 hour.  
Refer to M.D. if remains > 140/90.**II. TESTING – (LPN or RN)**

RESULTS

Tuberculin Skin Test (q yr)

Date given 5/18/05 Site FAPast Positive TB Skin Test  
(Chest x-ray if clinical symptoms)Read on 5/20/05 Results + mm

RPR (q 3 yrs)

Survey Completed

EKG (baseline at 35, over 45 q 3 yrs)

Date Results

Cholesterol (at 35 then q 5 yrs)

Date 5/24/04 Results NRTetanus/Diphtheria (q 10 yrs)  
(if done today)Date 5/18/05 Results Normal

Optometry Exam (@ 50 if not already seen)

Date 1-10-05 Results 167

Mammogram

Last Given 5-18-05 Due 5-20-05

(females @ 40, q 2 yrs/other M.D. order)

Site given ODU Dose 0.5 Lot # 4135/AADate N/A

Results

**III. PHYSICAL RESULTS – (RN, Mid-Level, M.D.)**

Heart

Reg Rhythm

Lungs

Clear

Breast Exam

N/A

Rectal (yearly after 45)  
with Hemocult

Results

Results

Pelvic and PAP (q 1 yr)

Date N/A

Results

Facility Truklee Nurse Signature [Signature]Date 5/18/05M.D. or Mid-Level Signature [Signature]

Date

INMATE NAME

AIS#

D.O.B.

RACE/SEX

James John2348218/14/58[Redacted]W/M



## DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE  
PHYSICAL ASSESMENTANY OPEN SORES OR RASHES ON  
HANDS, ARMS, FACE & NECK

YES

NO

✓

TB TEST CURRENT

✓

DOES PT. SHOW ANY OBVIOUS  
SIGNS OF ANY OTHER DISEASE

OTHER:

Inmate  
states he hasHepatitis C  
Hep C

THIS PATIENT HAS BEEN INFORMED OF THE NEED FOR THE FOLLOWING:

PROPER HANDWASHING, NOT TO HANDLE FOOD WHILE SICK, SEEK MEDICAL  
EVALUATION WHEN NECESSARY AND TO NOTIFY THE DIETARY SERVICES SHIFT  
SUPERVISOR OF ANY ILLNESS.

MEDICAL AUTHORITY:

DATE:

I attest that the above statement is true to the best of my knowledge.

PATIENT SIGNATURE:

DATE:

EXPIRATION DATE:

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

Race/Sex

FAC.

Shuman, John

034821

[REDACTED]

W/M

FLYC



DEPARTMENT OF CORRECTIONS  
NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

Name Joan Annman Relationship Mother  
 Street Address 1104 Frances St Phone Number (256) 381-9065  
 City Tusculumbia State AL Zip Code 35674  
 Inmate Signature John Annman Doc# 234821 S.S.# [REDACTED] Date 5-19-05  
 Witness [Signature] Date 5/18/05

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	RACE/SEX	FAC
<u>Annman John</u>	<u>234821</u>	<u>[REDACTED]</u>	<u>W/M</u>	<u>Flyc</u>

## INTAKE HEALTH APPRAISAL

NAME: Inman, John  
 AIS#: 234821  
 D.O.B.: [REDACTED] R/S W/m

HEALTH CLASSIFICATIONS:  
(Circle One)1 - No Restrictions2 - Temporary Restrictions  
See Special Needs Form3 - Permanent Restrictions  
See Special Needs Form

4 - A&amp;I (Aged &amp; Infirm)

5 - Not Determined  
Recheck \_\_\_\_\_

## PLACEMENT:

General Population ☒Emergency Department ☐Isolation ☐Medical Observation ☐

Other \_\_\_\_\_

## REFERRAL:

CCC Placement ☐Clinic(s) N/ASee MD/Mid-Level flow sheet  
for clinic(s).Medical ☐Dental ☐Mental Health ☐

Other \_\_\_\_\_

When: ☐ Immediately☐ Next Sick Call

## IMMUNIZATIONS ORDERED:

Medications Ordered: \_\_\_\_\_

APPRAISAL	N	Abn/Comment
General Movement Deformity Pain, Bleeding Habit, Hygiene	/	
Neuro Mental Status Intox Withdrawal, Tremor Neuro-Deficits	/	Alo x 3
Skin Injury, Bruises, Trauma Jaundice Diaphoretic Rash, Lesions, Infestations Needle Marks Color, Turgor	/	Back. ① arm tattoo ③ Knee Scars
Head Normocephalic Atraumatic Hair, Scalp	/	
Eyes Glasses/Vision Pupils Sclera, Conjunctiva	/	PERRA
Ears Appearance Canals, TMs, Hearing	/	Cerumen
Nose Epistaxis Sinuses	/	
Throat Teeth, Gums, Dentures Mouth, Tongue, Tonsils Airway	/	
Neck C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes	/	From
Chest Config, Ausc/Resp Cough/Sputum Breast/Masses	/	CTA ⑤
Heart Ausc Rate, Rhythm Murmurs, Ectopy	/	R R R
Abdomen Bowel Sounds Palp, G/R/T, Hernia	/	④ BS x 4
GU Flank Tenderness Bladder Tenderness/Distention	/	
Back ROM, Spasm, Injury	/	From
Extremities Edema, Pulse	/	MAEW
Genitals Injuries/Lesions	/	
Pelvic Pap	N/A	
Rectal/Gulac (required @ 45 and up) Deferred/follow-up:	/	x B/B Stools

M.D. or Mid-Level Signature

Date/Time

5/25/04 1305





## INTAKE SCREENING

NY Hep C

Date: 5-24-04	AIS#: 234821	
Last Name: Inman	First: John	Middle: David
Birthplace: Cleveland, Ohio	DOB: [REDACTED]	SS#: [REDACTED]

FEMALES: Pregnancy test: (circle one) <u>Positive</u> Negative	B/P 126/82 Temp	Pulse	Resp	Weight
FSBS	If level > 200, repeat within 48 hours. Above 300 call M.D.			

Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where? Brice, VA Bi-polar manic depressive, anxiety, explosive	
Previous Incarcerations (Date & Facility) none No prostate problems disorde	
Medications: <input type="checkbox"/> None <u>Prozac, Trazodone, Xanax</u>	Special Diet (Prescribed) <u>none</u>
Allergies: <u>WKA</u>	Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form) <u>NO</u>

ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING, IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE

## CLINICAL OBSERVATIONS

1) Level of Consciousness: <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented; time, place, person ( ) Lethargic ( ) Stuporous ( ) Comatose Describe:	3) Substance Abuse: <input checked="" type="checkbox"/> Yes ( ) No ( ) Suspected ( ) Current intoxication/Abuse <input checked="" type="checkbox"/> Use ( ) Withdraw Symptoms ( ) Drugs ( ) Alcohol Describe- What kind? Amount/Frequency? <u>NY smoking crack, cocaine IV</u> • If confirmed Benzo use, then call M.D. If can not be confirmed, call M.D. Last Use: (Time/Date):
2) General Appearance: <input checked="" type="checkbox"/> Normal ( ) Abnormal	4b) Affect/Mood: ( ) Normal ( ) Manic ( ) Depressed ( ) Euphoria ( ) Flat ( ) Emotionally Confused Describe:
3) Signs of Trauma: ( ) Yes <input checked="" type="checkbox"/> No	4a) Behavior/Conduct: <input checked="" type="checkbox"/> Calm ( ) Agitated ( ) Uncooperative ( ) Violent ( ) Manipulative ( ) Disorganized Describe:
4c) Perceptions: ( ) Delusional <input checked="" type="checkbox"/> Hallucinations <input checked="" type="checkbox"/> Hearing Voices <u>occasional</u>	5b) Does pt describe current suicidal thoughts or ideations? ( ) Yes <input checked="" type="checkbox"/> No
5a) Is there h/o actual suicide attempt? <input checked="" type="checkbox"/> Yes ( ) No	5d) High risk pt may become assaultive towards staff? ( ) Yes <input checked="" type="checkbox"/> No
5c) Is there evidence If ANY of the above in #5 are circled, staff MUST describe here, include previous history and dates: <u>Self mutilation @ forearm</u>	Triggers for Suicide Watch - Currently Suicidal - History of actual attempt - Fails to maintain control Y or N
*Any abnormal observations #4 or 5 require immediate Mental Health Referral	Triggers for Close Watch Emotionally distraught and unable to regain composure by end of intake process - Actively hallucinating or not making any sense Y or N
6a) Communication Difficulties: ( ) Yes <input checked="" type="checkbox"/> No	6b) Memory Defects: ( ) Yes <input checked="" type="checkbox"/> No
6c) Hearing Impairment: ( ) Yes <input checked="" type="checkbox"/> No	6d) Speech Difficulties: ( ) Yes <input checked="" type="checkbox"/> No
7) Physical Aids: ( ) None <input checked="" type="checkbox"/> Glasses ( ) Contacts ( ) Hearing Aid ( ) Dentures ( ) Cane ( ) Crutches ( ) Walker ( ) Wheelchair ( ) Braces ( ) Artificial Limb ( ) Other	
8) Additional comments, complaints, symptoms: <u>None</u>	
S) <u>None</u>	
O) Fever Y <input checked="" type="checkbox"/> N Swollen Glands Y <input checked="" type="checkbox"/> N Signs of Infection Y <input checked="" type="checkbox"/> N Skin Intact Y <input checked="" type="checkbox"/> N	
A)	
P)	

If known Diabetic \* Call M.D. for order

Initial Insulin given:

I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for health services to be provided to me by and through PRISON HEALTH SERVICES.

Inmate's Signature/Date

Health Provider Signature/Date



I have read the *access to health care* information sheets and have been given a copy. I understand how to access health care.

Name John Duman Date 5-25-04  
AHS# 234821

Medical Staff Mandy, RN Date 5-25-04

Name: \_\_\_\_\_

Inmate #: \_\_\_\_\_

DOB: \_\_\_\_\_

Race: \_\_\_\_\_

Gender: \_\_\_\_\_

## Physician's Chronic Care Clinic

Date: 7/18/05 Time: 940/p Facility: FLUCCheck all applicable CICs being evaluated: Card/HTN DM GI ID PUL SZ TB Hep COBJECTIVE: BP 118/78 HR 76 RR 20 Temp 98.2 Wt 18 Peak Flow \_\_\_\_\_

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,

Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,

Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

⑦ Hep C Bletchy Rash

LFTS 5/25

AST 109  
ALT 33Pt C/O neck pain 20  
to MVA. Has seen Dr. Pearson  
7/05 will schedule PTV05 AST 91  
ALT 177

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's

Visit. Degree of Control: G=Good, F=Fair, P=Poor

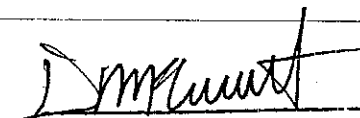
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I S W

PLAN:

F/U: Routine 90 days: X

Other: \_\_\_\_\_

  
 Physician MD
Problem List updated: Yes No

(01/31/05)

INMATE NAME	NUMBER	AGE	RACE/SEX
Inman, John	234821		W/M

Name: \_\_\_\_\_

Inmate #: \_\_\_\_\_

DOB: \_\_\_\_\_

Race: \_\_\_\_\_

Gender: \_\_\_\_\_

## Physician's Chronic Care Clinic

Date: 3/15/05 Time: 10:17 AM Facility: FranklinCheck all applicable CICs being evaluated: Card/HTN DM GI ID PUL SZ TB 46COBJECTIVE: BP 96/70 HR 84 RR 20 Temp 96.7 Wt 180 Peak Flow \_\_\_\_\_

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

① Hep C

② Green Rhinorrhea + cold s +  
2 months  
will cover c ABX1/05  
AST 91  
ALT 177 ↑ from  
6/04  
will re ✓ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor  
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I S W

PLAN: monitor LFT's

F/U: Routine 90 days: X

Other: \_\_\_\_\_

  
 Physician MD
Problem List updated: Yes No

(01/31/05)

INMATE NAME

NUMBER

AGE

RACE/SEX

Iman, Sahn

234821

47

W/M

## PRISON HEALTH SERVICES

Name: \_\_\_\_\_  
 Inmate #: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

## Nurse's Chronic Care Clinic

Date: 3/15/05 Time: 1017AM Facility: Franklee

Check all applicable CICs being evaluated: Card/HTN DM GI ID PUL SZ TB HepC

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: \_\_\_\_\_ Dates: \_\_\_\_\_

See attached for monofilament check.

For asthma patients, list the # of asthma attack visits since the last CIC visit: \_\_\_\_\_ Dates: \_\_\_\_\_

For seizure patients, list the # of witnessed seizures since the last CIC visits: \_\_\_\_\_ Dates: \_\_\_\_\_

ALLERGIES: NKA CURRENT DIET: Regular

DESCRIBE MED AND DIET ADHERANCE: No longer on Inderal - Expired

DESCRIBE ANY MED SIDE EFFECTS: Still having neck pain

VACCINES: Flu \_\_\_\_\_ Pneumovax \_\_\_\_\_ Hep A \_\_\_\_\_ Hep B \_\_\_\_\_

For asthma pts, list the number of short-acting inhaler canisters refilled in the past month: \_\_\_\_\_

(\*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c \_\_\_\_\_ on \_\_\_\_\_; CD4 & HIV-RNA 1 on \_\_\_\_\_;  
 Peak Flow \_\_\_\_\_; LFTs ✓ on 1/18/05; Serum Drug Levels \_\_\_\_\_ on \_\_\_\_\_; EKG \_\_\_\_\_; CXR ✓ 6/21/04

BMP SCR/BUN 1/18/05 - Diagnostic Panel 1/10/05

## MEDICATIONS:

Inderal 20mg  $\dot{\div}$  PO q day?

Patient Educated on:

Hep C - verbal only

Inmate Signature John Inman

Nurses Signature and Title [Signature]

INMATE NAME	D.O.B.	AGE	RACE/SEX	ID #
<u>Inman, John</u>	<u>[REDACTED]</u>	<u>47</u>	<u>WM</u>	<u>234821</u>

(01/31/05)

PATIENT NAME	JIMMAN John		ID NUMBER	834821	DATE	2-7-05	FACILITY	Franklin				
Step 1	Patient is positive for the Hepatitis C virus. (Quantitative HCV obtained.) <input type="checkbox"/> Patient given Schering-Plough or Pegasys "Medication Guide," as appropriate. <input type="checkbox"/> Provider educates patient on Hepatitis C infection and treatment. The education has been documented. PROVIDER SIGNATURE: <u>[Signature]</u> DATE: <u>2-7-05</u>											
Step 2	Initiate eligibility process <input type="checkbox"/> Patient signed Informed Consent or refusal for determining eligibility for Interferon/Ribavirin treatment. <input type="checkbox"/> Obtain labs as required to determine eligibility. (If no other absolute exclusion criteria are present.) PROVIDER SIGNATURE: _____ DATE: _____											
Step 3	<table border="1"> <thead> <tr> <th>Absolute Exclusion Criteria*</th> <th>Relative Exclusion Criteria**</th> </tr> </thead> <tbody> <tr> <td> <input type="checkbox"/> Age <math>\leq 18</math> or <math>\geq 60</math>  <input checked="" type="checkbox"/> Remaining incarceration time <math>\leq 24</math> months.  <input type="checkbox"/> Presence of an Axis I diagnosis that is not controlled and stable as determined by the treating psychiatrist  <input type="checkbox"/> History of solid organ transplant.  <input type="checkbox"/> Presence or history of an autoimmune disorder.  <input type="checkbox"/> Presence or history of decompensated cirrhosis, presence or history of ascites or encephalopathy (albumin <math>\leq 3.2</math> gm/dl, bilirubin <math>&gt; 3.0</math> gm/dl).  <input type="checkbox"/> CBC results outside acceptable limits (Hgb <math>\leq 12</math> females, <math>\leq 13</math> for males; WBC <math>&gt; 3,000</math>; ANC <math>\leq 1,500</math> &amp; platelets <math>\leq 100,000</math>/mm).  <input type="checkbox"/> Creatinine <math>\geq 1.7</math> or creatinine clearance <math>\leq 50</math> ml/minute.  <input type="checkbox"/> Normal ALT (<math>&lt; 2.0</math> times normal at 0, 3 and 6 months)  <input type="checkbox"/> Positive pregnancy test.  <input type="checkbox"/> Active TB  <input type="checkbox"/> Auto Immune Disease e.g. -- Lupus, Graves Disease, R.A., M.S., Myasthenia Gravis  <input type="checkbox"/> Cancer -- not in remission  <input type="checkbox"/> Hemoglobinopathies                 </td> <td> <input type="checkbox"/> Hepatitis B Co-infection  <input type="checkbox"/> Diabetes -- poorly controlled with Hgb. A1C <math>\geq 9.0</math>  <input type="checkbox"/> Ischemic Cardiac Disease or Cerebrovascular Disease  <input type="checkbox"/> Hypertension -- poorly controlled  <input type="checkbox"/> CHF  <input type="checkbox"/> Peripheral Vascular Disease -- Symptomatic  <input type="checkbox"/> COPD -- severe  <input type="checkbox"/> Seizures -- poorly controlled  <input type="checkbox"/> Active Thyroid Disease  <input type="checkbox"/> Active Gout  <input type="checkbox"/> Significant CNS Trauma -- recent within the past six months  <input type="checkbox"/> Poor adherence to treatment including <math>\leq 80\%</math> of clinic visits and medications, to the extent the inmate made the choices.  <input type="checkbox"/> Alcohol and illicit drug use within one year.  <input type="checkbox"/> Interferon/Ribavirin sensitivity.  <input type="checkbox"/> Life expectancy <math>&lt; 10</math> years.                 </td> </tr> </tbody> </table> <p>* "No further evaluation should be completed so long as the absolute criterion exists."</p> <p>**The provider is required to review relative exclusion criteria with the Regional Medical Director prior to proceeding with further evaluation.</p>								Absolute Exclusion Criteria*	Relative Exclusion Criteria**	<input type="checkbox"/> Age $\leq 18$ or $\geq 60$ <input checked="" type="checkbox"/> Remaining incarceration time $\leq 24$ months. <input type="checkbox"/> Presence of an Axis I diagnosis that is not controlled and stable as determined by the treating psychiatrist <input type="checkbox"/> History of solid organ transplant. <input type="checkbox"/> Presence or history of an autoimmune disorder. <input type="checkbox"/> Presence or history of decompensated cirrhosis, presence or history of ascites or encephalopathy (albumin $\leq 3.2$ gm/dl, bilirubin $> 3.0$ gm/dl). <input type="checkbox"/> CBC results outside acceptable limits (Hgb $\leq 12$ females, $\leq 13$ for males; WBC $> 3,000$ ; ANC $\leq 1,500$ & platelets $\leq 100,000$ /mm). <input type="checkbox"/> Creatinine $\geq 1.7$ or creatinine clearance $\leq 50$ ml/minute. <input type="checkbox"/> Normal ALT ( $< 2.0$ times normal at 0, 3 and 6 months) <input type="checkbox"/> Positive pregnancy test. <input type="checkbox"/> Active TB <input type="checkbox"/> Auto Immune Disease e.g. -- Lupus, Graves Disease, R.A., M.S., Myasthenia Gravis <input type="checkbox"/> Cancer -- not in remission <input type="checkbox"/> Hemoglobinopathies	<input type="checkbox"/> Hepatitis B Co-infection <input type="checkbox"/> Diabetes -- poorly controlled with Hgb. 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Step 4	Non-Formulary Request for Genotype Testing <input type="checkbox"/> Obtain HCV genotype. Provider submits Non-formulary Lab Request form with a copy of this form to the Regional Medical Director. Approval must be received prior to ordering tests. STAFF SIGNATURE: _____ DATE: _____											
Step 5	Risk Stratification and Treatment Options <input type="checkbox"/> Provider reviews test results with patient to determine risk stratifications and therapeutic options. <input type="checkbox"/> Provider submits an Outpatient RMD Consultation form for a liver biopsy, if indicated, with a copy of this form to the Regional Medical Director. Approval must be received prior to scheduling the biopsy. PROVIDER SIGNATURE: _____ DATE: _____											
Step 6	Initiation of Treatment <input type="checkbox"/> Final eligibility determination completed. Liver biopsy results have been reviewed with the Regional Medical Director. <input type="checkbox"/> Provider reviews Schering-Plough or Pegasys "Medication Guide" with the patient and provides education on Interferon/Ribavirin treatment. <input type="checkbox"/> Patient signs informed consent for Interferon/Ribavirin treatment, a second time. <input type="checkbox"/> Provider completes Formulary Exception Request form and orders medication treatment. PROVIDER SIGNATURE: _____ DATE: _____											
Step 7	Safety and Efficacy Monitoring <input type="checkbox"/> Provider orders appropriate hematological and biochemical testing and viral load testing as required on the HCV treatment flow sheet. The provider addresses compliance at each visit and asks specific questions for depression and suicidal ideation. PROVIDER SIGNATURE: _____ DATE: _____											



DEPARTMENT OF CORRECTIONS  
PHYSICIAN'S  
CHRONIC CARE CLINIC  
SPECIAL NEEDS

DATE	TIME		DATE ORDERED	TIME ORDERED	
2/7/05	1230	S: 30 DAY CHRONIC CARE CLINIC			ALLERGIES
		O: VS T9P P76 R 18 BP 102/74 WI 170			
		REVIEW OF NURSES CCC RECORD			
		YES NO 1st visit			
		NOTES			
		Dr of Hep C discussed inmate. Aware of same. C dx in 1984. Transmission and treat ment. Discussed. Will not qualify for treatment Due to EOS.			P: LABS
		Will place in CC with PND.			ORDERS:
		Discussed: 7 high virus Will try diet, exercise & cigs (15 pm day) 7/12 3mg may need agent			MEDICATION:
					F/U CCC WITH NURSE EVERY 6 DAYS MD
					F/U CCC WITH MD EVERY 12 DAYS. MD
					SIGNATURE:
		EDUCATION DONE YES NO Handout given			

INMATE NAME INMATE, John	D.O.B. [REDACTED]	AGE 50	RACE/SEX W/M	ID # 234821
-----------------------------	----------------------	-----------	-----------------	----------------



John Iman 234821

needs IN Auto Week

Chg \$ 3.00

Diaper

~~W~~ Warden William

MS Jones

547

Refund

MS

MS. Pstln  
Counsel

Team

**ALABAMA DEPARTMENT OF CORRECTIONS**  
**INMATE ORIENTATION TO MENTAL HEALTH SERVICES**

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

***This information on this form has been explained to me and I have received a copy of the information for my future reference.***

Inmate Signature

234821  
AIS #

5/24/04  
Date Signed

INMAN John

DEPARTMENT OF CORRECTIONS  
MENTAL HEALTH SERVICE  
ABNORMAL INVOLUNTARY MOVEMENT SCALE (MODIFIED)

INVOLUNTARY MOVEMENT RATING  
— Rate highest severity observed Rate movements  
that occur upon activation one less than those  
observed spontaneously

CODE  
0 – Normal, no involuntary movement  
1 – Minimal, fleetingly present  
2 – Mild, occurs more than four times  
3 – Moderate, persistent  
4 – Severe, very pronounced and continuous

FACIAL AND ORAL MOVEMENTS	MUSCLES OF FACIAL EXPRESSION: movements of forehead, eyebrows, periorbital area, cheeks; includes frowning, blinking, smiling, grimacing	0 1 2 3 4
	LIPS AND PERIORAL AREA: puckering, pouting, smacking	0 1 2 3 4
	JAW: biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4
	TONGUE: rate only increase in movement both in and out of mouth NOT inability to sustain movement	0 1 2 3 4
EXTREMITY MOVEMENTS	UPPER (arms, wrists, hands, fingers): include choreic movements (rapid, objectively purposeless, irregular, spontaneous), athetoid movements (slow, irregular, complex, serpentine). DO NOT INCLUDE tremors (repetitive, regular, rhythmic)	0 1 2 3 4
	LOWER (legs, knees, ankles, toes): lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4
TRUNK MOVEMENTS	NECK, SHOULDER, HIPS: rocking, twisting, squirming, pelvic gyrations.	0 1 2 3 4
GLOBAL JUDGEMENTS	SEVERITY OF ABNORMAL MOVEMENTS	0 1 2 3 4
	INCAPACITATION DUE TO ABNORMAL MOVEMENTS	0 1 2 3 4
	PATIENT'S AWARENESS OF ABNORMAL MOVEMENTS: rate only patient's report	0 1 2 3 4
	0 – No awareness 1 – Aware, no distress 2 – Aware, mild distress 3 – Aware, moderate distress 4 – Aware, severe distress	
DENTAL STATUS	<sup>2 DENTAL CHIEFS</sup> CURRENT PROBLEMS WITH TEETH AND/OR DENTURES	NO YES
	DOES PATIENT USUALLY WEAR DENTURES?	NO YES

Assessed by: [Signature] Date: 9/8/04  
Reviewed by: [Signature] Date: 9/8/04

Inmate Name

INMANS, JOHN

AIS #

234821

**PSYCHOLOGICAL INTERVIEW/DATA ENTRY FORM**

Name: Shirley A. Baker AIS#: 234821 R/S: W/10/07  
 Date: 5/27/04 Date of Birth: [REDACTED] Age: 45

Beta II: 88 WAIS: 111 WRAT-RL: 17.2  
 Last School Grade Completed: 12 Special Education Classes: Yes No

MMPI Welsh Code: 430/92/15/673 Megargee Type: #2-K/F#

**General Appearance**

- ☒ a. Neat and generally appropriate ☐ c. Flat or avoiding interaction  
☐ b. Poorly groomed ☐ d. Sad or worried  
☒ e. Other\* mental patient

**I. Interpersonal Functioning**

- ☐ a. Normal-good relationships likely ☐ d. Lacks skill or confidence  
☐ b. Withdrawn/apparent loner ☐ e. Probably difficult to get along with  
☐ c. Likely to ignore rights/needs

Other\* (Specify) 1. 2. 3. 4. ☒ 5. 6.  
 (See Copy)

**II. Personality**

- ☐ a. Healthy ☐ d. Explosive  
☒ b. Antisocial ☐ e. Dependent  
☐ c. Paranoid ☐ f. Passive-Aggressive

Other\* (Specify) 1. Schizoid 4. Narcissistic 7. Compulsive  
2. Schizotypal 5. Borderline 8. Atypical/mixed  
3. Histrionic 6. Avoidant

☒ 9. See Copy (Write in your wording)

**III. Substance Abuse**

☐ a. Alcohol addiction/abuse history Denies

☒ b. Drug addiction/abuse history Claims terminated  
all use of alcohol April 2003.

N-259 (2/2001)

White to Central Records  
 Yellow to Institutional File  
 Pink to Medical Record

\* See manual for selections and numbers for "other"

RECEIVED JUN 01 2004

## PSYCHOLOGICAL INTERVIEW/DATA ENTRY FORM

Page 2

Name:

*Alman, John*III. Substance Abuse (continued)c. Current use *Denies*d. Current addiction *Denies*

Other\* (Specify): 1. 2. 3. 4. 5. 6. 7. 8.

IV. Emotional Status

a. No significant problems

b. Depressed

✓ c. Anxious or stressful *Reactive*

d. Angry or resentful

e. Confusion or psychotic symptoms *History of suicidal gestures and psychotic episodes*f. Mood disturbances *Major depressive disorder*

g. Sexual maladjustment

History of sex offenses?

Yes

No

h. Paranoid ideation

i. Sleep/appetite disorder

Other\* (Specify): 1. 2. 3. 4. 5. 6. 7. 8. 9.

(See Copy)

Emotional response to incarceration: *OK*V. Mental Deficiency

a. Mild

b. Moderate

c. Severe

d. Borderline

e. Organic impairment suspected

f. Memory deficit

Remarks:

History of cerebral trauma or seizures?

Yes

No

*Assaulted during drug buy w/ head & skull injury*

\* See manual for selections and numbers for "other"



## PSYCHOLOGICAL INTERVIEW/DATA ENTRY FORM

Page 3

Name:

Almon, JohnMental Health History

- ☒ a. Outpatient treatment (dates/where) Mental Health Center  
in Glendale, CA
- ☒ b. Inpatient treatment (dates/where) V.A. Hospital in 2003
- ☒ c. Psychotropic medication (type/effectiveness) Mellin's, Miltamine,  
per se power of anxiety, Kollipin, Kollipin
- ☐ d. Family history of mental illness

VI. Management Problems

- ☒ a. Suicide potential Ideation? Yes No Plans? Yes No  
 History of attempts/gestures 2000 Attempted suicide by cut
- ☒ b. Serious mental illness (specify) 47 Arm - Turist step per the  
Pressure over drug addiction
- ☒ c. Impulsive /acting out behaviors predicted
- ☐ d. Authority conflict
- ☒ e. Manipulative/untrustworthy past conviction (BTE  
and vandalizing a home)
- ☐ f. Easily victimized
- ☐ g. Escape potential
- ☐ h. Assaultiveness

History of expressively violent behavior?

Yes

No

Other\* (Specify) 1. 2. 3. 4. 5. 6. 7. 8. 9.

(See Copy)

VII. Educational Needs

- ☐ a. ABE ☐ b. Special Education ☒ c. Trade School ☐ d. Junior College

VIII. Mental Health Needs

- ☐ A. Refer to psychiatrist ☐ E. Sexual adjustment ☒ I. Self-concept enhancement
- ☐ B. Substance abuse counseling ☒ F. Reality therapy ☒ J. Healthy use of leisure
- ☐ C. Depression ☐ G. Anger-induced acting out ☐ K. Personal development
- ☒ D. Stress management ☒ H. Values clarification

## RECOMMENDATIONS/REMARKS:

ISAD per Court Proceedings  
plus alone diagnoses & mental  
problems noted

MENTAL HEALTH CODE:

SMI

HARM

HIST

NONE

Evaluation Completed by:

John C. Almon

Date:

5/5/04

\* See manual for selections and numbers for "other"



SIGNATURE

RTC in 90 days. Will follow up  
w/ counseling & MHP. After  
90 days if I'm still clinically  
stable, may consider downcoding  
his mental health code to H1ST.  
RTC PRN. Continue care.

S. Damerjee, MD.

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
INMAN JOHN	234821		W/M	DRAPE

## INTERDISCIPLINARY PROGRESS NOTES

DATE TIME

NOTES

SIGNATURE

8/12/04 10<sup>45</sup> a

S I'm having problems with my meds. I've been having real bad dreams.

O A & O X3. Normal mood & affect. No sign of depression or anxiety. Denied HI/SI at present. Denied A/V hallucination. No psychotic symptoms noted. Sleep alteration noted, no appetite disturbance. MHP informed inmate to report problems with meds at any time via sick call request. MHP discussed importance of taking meds as prescribed.

A Axis I: Bipolar D/O

P Continue care.

CRG, MZ, MHP

8/17/04

S: In seen. Stated "I am not going to take so much of medicine. I want to take the lowest dose. I am doing good." Denies of any sx's of mood, anxiety or thought d/o at this time. Denies of any thoughts to hurt (Continued)

Chart  
review  
[Signature]

Patient's Name (Last, First, Middle)	Alc#	Age	R/S	Facility
Inman, John	234821		W/M	Draper

## II. DISCIPLINARY PROGRESS NOTES

DATE	TIME	NOTES	SIGNATURE
7/13/04		<p>Thought content: <math>\phi</math> SI, <math>\phi</math> HI, <math>\phi</math> HA, <math>\phi</math> delusions, <math>\phi</math> paranoia, <math>\phi</math> other.</p> <p>Sxs of psychosis noted at this time. Cognitive: Alert, oriented x3. Insight: Poor, Judgment: Impaired.</p> <p>A: Axis I: Bipolar I/0</p> <p>P: Will continue current tx plan. Rtc in 90 days. Im clinically stable at this time. PRN mental health. Continue care.</p>	
			Spencer, MD

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
INMAN, JOHN	234821	45	W/M	DRAPER

**ALABAMA DEPARTMENT OF CORRECTIONS  
MENTAL HEALTH SERVICES  
TREATMENT PLAN: OUTPATIENT CARE**

Treatment Plan Initiated on: 6/4/04 Treatment Coordinator: Russell, MS-MHP

Inmate's Housing Location: \_\_\_\_\_ Institution: KCF

DSM-IV Diagnosis: \_\_\_\_\_  
Axis I: Bipolar Disorder; NDS, substance dependence

Axis II: Depressed

Axis III: Crime Reported

Axis IV: incarceration

Axis V: 60

Procurrent Symptoms		Problem #1	<u>MS/Bipolar Disorder</u>
Goal: <u>Maintain Stabilization MHS services</u>			
Target Date for Resolution: <u>ongoing</u>			
Intervention:			
<u>① Meds</u> <u>② Counseling</u>			
Staff Member Responsible: <u>MHS Staff</u>		Frequency: <u>monthly</u>	

Drug Substance		Problem #2	<u>dependence</u>
Goal: <u>Delete drugs from daily living</u>			
Target Date for Resolution: <u>ongoing</u>			
Intervention:			
<u>Recommend S/P when available</u>			
Staff Member Responsible: <u>Doc Staff</u>		Frequency: <u>upon Doc</u>	

Goal:		Problem #3
Target Date for Resolution:		
Intervention:		
Staff Member Responsible:		
Frequency:		

Second Page attached: Yes ☐ No ☒

Psychiatrist: Dr. Russell Treatment Team Members

Mental Health Nurse: Dr. Russell

Treatment Coordinator: Russell, MS-MHP

Date: 6/4/04

Date: 6/4/04

Date: 6/4/04

Inmate Agreement: John Linman

Treatment Plan Review to be Conducted by:

Date: 6/4/04

(within six months)

Inmate Name	AIS #
<u>Linman, John</u>	<u>234821</u>

ALDOC Form 463-01

Page \_\_\_ of \_\_\_

AMA DEPARTMENT OF CORRECTIONS  
MENTAL HEALTH SERVICES  
REFERRAL TO MENTAL HEALTH

Inmate Name: INMAN, JOHN AIS# 234821 Date of Referral: 5-24-04

REASON FOR REFERRAL:

- ☐ CRISIS INTERVENTION
- ☐ Family problem: \_\_\_\_\_
- ☐ Problems with other inmates: \_\_\_\_\_
- ☐ Recent stress: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

**EVALUATION OF MENTAL STATUS**

- ☐ Suicidal
- ☐ Homicidal
- ☐ Mutilative
- ☐ Hostile, angry
- ☐ Other inappropriate behavior: \_\_\_\_\_
- ☐ Anxious
- ☐ Depressed
- ☐ Withdrawn
- ☐ Poor hygiene
- ☐ Physical complaints
- ☐ Sleep disturbance
- ☐ Hallucinations/delusions
- ☐ Suspicious

☐ EVALUATION OF NEED FOR PSYCHIATRIC EVALUATION

☒ HISTORY OF PSYCHOTROPIC MEDICATION PRIOR TO RECEPTION/TRANSFER

☒ OTHER:

COMMENTS: TRAZADONE 200mg QHS  
REMERON 45mg QD  
KLOXIPIN 3mg QD

Referred by: V. O. Wesson

**Phone Contact #:**

- ☐ Referral for psychiatrist (referral has been screened by mental health or medical staff)

**MENTAL HEALTH FOLLOW-UP: EVALUATION/TREATMENT/DISPOSITION**

Follow-Up by:

Date: \_\_\_\_\_

Inmate Name

AIS #

\*\*\*\*\* MMPI-2 ADULT INTERPRETIVE SYSTEM \*\*\*\*\*

developed by

Roger L. Greene, Ph.D.  
Robert C. Brown, Jr., Ph.D.  
and PAR Staff

-- CLIENT INFORMATION --

Client : INMAN, JOHN Age : 45  
Sex : Male Marital Status :  
Education : Date of Birth [REDACTED]  
File Name : 234821

Prepared for: Kilby Correctional Facility on 05/26/2004

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The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual. This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.

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## MMPI-2 INTERPRETIVE REPORT

PREPARED FOR: Kilby Correctional Facility

PAGE 2

## -- MMPI-2 PROFILE FOR VALIDITY AND CLINICAL SCALES --

	L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	
110	--	--	--	+	--	--	--	--	--	--	--	--	--	-- 110
				+										
				+										
				+										
100	--			+										-- 100
				+										
				+										
				+										
90	--			+										-- 90
				+										
				+										
				+										
80	--			+										-- 80
				+										
				+										
				+										
70	--			+										-- 70
				+										
	*	--	--	+	--	--	--	--	--	--	--	--	--	
				+										
60	--			+										-- 60
				+										
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			*	+			*							
50	--	--	--	+	--	--	--	--	--	--	--	--	--	-- 50
				+	*							*		
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				+										
40	--	*		+	*			*		*				-- 40
				+						*	*			
				+										
				+										
30	--			+										-- 30
				+										
				+										
				+										
20	--	--	--	+	--	--	--	--	--	--	--	--	--	-- 20

	L	F	K	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
--	---	---	---	----	---	----	----	----	----	----	----	----	----

T-Score	65	39	51	42	47	50	54	42	39	37	37	47	50
---------	----	----	----	----	----	----	----	----	----	----	----	----	----

Unanswered (?) Items = 197

Welsh Code: 430/9215:678# L-K/F#

MMPI-2 INTERPRETIVE REPORT  
 PREPARED FOR: Kilby Correctional Facility

PAGE 3

-- PROFILE MATCHES AND SCORES --

Scale	Client Profile	Highest Scale Codetype	Best Fit Codetype
Codetype match:		WNL	None
Coefficient of Fit:		.63	
-----			
Scores:	? (raw)	197	
	L	65	55
	F	39	51
	K	51	46
	Hs (1)	42	47
	D (2)	47	52
	Hy (3)	50	45
	Pd (4)	54	52
	Mf (5)	42	44
	Pa (6)	39	47
	Pt (7)	37	46
	Sc (8)	37	45
	Ma (9)	47	49
	Si (0)	50	49
-----			
Mean Clinical Elevation:	44	48	
Ave age-males:		38	
Ave age-females:		40	
% of male codetypes:		18.6%	
% of female codetypes:		11.5%	
-----			
% of males within codetype:		79.0%	
% of females within codetype:		21.0%	
-----			

Configural clinical scale interpretation is provided in the  
 report for the following codetype(s):

WNL

MMPI-2 INTERPRETIVE REPORT  
PREPARED FOR: Kilby Correctional Facility

PAGE 7

Si (0) T = 50

Scores in this range are considered to be within normal limits.

-- ADDITIONAL SCALES --

No additional scales were selected for interpretation by the user.

END OF REPORT

\*\*\*\*\*